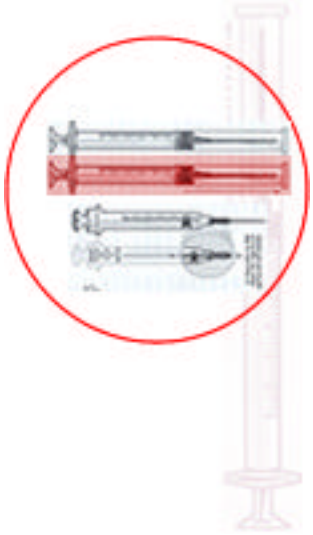
NIOSH recommends that health care facilities use safer medical devices to protect workers from needlestick and other sharps injuries. Since the passage of the Needlestick Safety and Prevention Act in 2000 and the subsequent revision of the OSHA Bloodborne Pathogen Standard, all health care facilities are required to use safer medical devices.

SAFER MEDICAL DEVICE IMPLEMENTATION IN HEALTH CARE FACILITIES

SHARING LESSONS LEARNED

NIOSH has asked a small number of health care facilities to share their experiences on how they implemented safer medical devices in their settings. These facilities have agreed to describe how each step was accomplished, and also to discuss the barriers they encountered and how they were resolved, and most importantly, lessons learned.



Safe Medical Devices Project

Phase Two

Facility Description

The Skilled Nursing Residence is a 139 bed teaching nursing home owned by a university. We are located on the university campus and serve as a clinical practice site for nursing students, as well as other students including, physical therapy and occupational therapy students, dietitian students, social work student and clinical pastoral education students. We operate three distinct units, a 39 bed Medicare Unit, a 31 bed Dementia Unit, and a 69 bed long term care unit.

1. Identifying the Priorities

The next step in our process was to identify the priorities for the facility. The goal of this phase was to determine the medical devices that would have the greatest impact on prevention of occupational exposure.

To begin, we looked at three areas:

- needlestick injury patterns
- safer medical devices currently in use
- OSHA regulatory requirements

There had been three needlestick injuries in the past year. In one instance, a needle was thrown into a wastebasket, and stuck a housekeeper, and in two instances nurses were stuck while they were carrying the needles to the disposal container. One nurse was injured by a needle that was shielded but the needle came through the shield. Another nurse did not shield the needle when he completed his injection and was injured when another staff person bumped into him accidentally. Analysis pointed to the injuries occurring as a result of needle disposal or the process of disposal.

The nursing staff in on the committee felt strongly that the safer medical devices related to needles, syringes and IV equipment were inherently safe, and that no further work needed to be done in this area. They felt strongly that the issues were related to disposal. Housekeepers agreed that needle disposal seemed to be a problem. They all agreed that more sharps disposal containers were needed. Sharps disposal containers was the safer medical device that the committee agreed we needed to work on.

Currently, there are no sharps disposal containers in resident's rooms. The sharps disposal containers are all located on the side of the medication administration carts. These containers are almost always full. Because they are located on medication administration carts, the housekeepers do not remove and replace them

because..."We don't have anything to do with medicines." The nurses remove and replace them only when there is absolutely no more space left in the container for another needle or syringe, allowing them to become overfull. This practice creates an unsafe work environment that has the potential to lead to injury. The committee agreed that this practice needed to be changed immediately.

The facility has 139 beds divided into three distinct units; a long-term care unit where most of our custodial care residents live, a dementia unit where our most medically stable population resides, and a Medicare unit, for short-term rehab and sub-acute clients. The Medicare Unit is the location where all three of the needlestick injuries occurred, and where most of the injections and IV therapy occurs. The committee decided that the Medicare unit needed to have a sharps disposal container in every room.

2. Developing the Plan

From the discussion and analysis the committee decided that their objective would be to develop a better system for the disposal of needles/sharps. One member suggested that a way to accomplish this would be to increase the number of sharps disposal containers throughout the facility. Another recommended that sharps disposal containers should be located in every resident room, so that they are easily accessible and convenient, and avoids carrying syringes, needles and IV supplies out of the room to a medication or treatment cart. Several members had seen this system in other health care organizations and agreed that having sharps disposal containers easily accessible was a desirable goal. The team decided to:

a. interview other staff regarding needle disposal issues
b. screen sharps disposal containers.

3. Recommendation

The members of the committee will discuss the plans with other staff in their departments to get feedback from more people. They will bring their findings back to the next meeting.

The committee wished to screen wall mounted sharps disposal containers to determine which type would be best suited to the needs of the staff and the facility. They agree that they wanted containers that were utilitarian, but were also aesthetically pleasing or, at least, "not ugly."

4. Next Steps

1. The purchasing agent will contact vendors and ask for samples of containers to be brought to the facility for screening. She will also get pricing information.

2. The members of the committee who were present will discuss needle/sharps disposal with their colleagues.

3. Next meeting will be set when the purchasing agent has a demonstration date from vendors. She will notify the facilitator re: available dates.

With those decisions made, the purchasing agent agreed to contact vendors and request a supply of different sharps disposal containers that the committee could screen at the next meeting.

5. Lessons Learned

The identification of the priorities took very little time, and the device identified was a surprise. I had expected a more laborious process, but it seemed a "no brainer" after we got all the key participants talking to each other. It proved to me yet again, as I learned years ago from process improvement teams in another organization, that it is important to have front-line staff on the committee. As the end user of the equipment, they are best prepared to analyze the strengths and weaknesses of a system, and to offer solutions. My advice to others is to be sure to include the users of the devices in order to assure that the administrative staff fully understands the issues.

Staff Hours:

Type of Staff	Hours Spent on Phase 2
Management	5
Administrative	5
Front-line	8
Total	18

Other, non-labor items:

Item
1. None
2.
3.
4.
5.